Saint Francis Hospital and Medical Center
Community Assistance Program
Eligibility Criteria On or After 07/01/2012

2011 Poverty Guidelines

FAMILY SIZE	ANNUAL GROSS INCOME POVERTY	200%	250%
1	10,890	21,780	27,225
2	14,710	29,420	36,775
3	18,530	37,060	46,325
4	22,350	44,700	55,875
5	26,170	52,340	65,425
6	29,990	59,980	74,975
7	33,810	67,620	84,525
8	37,630	75,260	94,075
9	41,450	82,900	103,625
10	45,270	90,540	113,175

SLIDING SCALE

RATE A = OWES MEDICARE ALLOWED AMOUNT

B = OWES MEDICARE ALLOWED AMOUNT

C = FULL ASSIST 100%

WEEKLY GROSS INCOME			MONTHLY GROSS INCOME			ANNUAL INCOME	SLIDING SCALE FAMILY SIZE									
							1	2	3	4	5	6	7	8	9	10
0	-	418	0	-	1,815	21,780	C	C	C	C	C	C	C	C	C	C
419	-	522	1,816	-	2,269	27,225	B	C	C	C	C	C	C	C	C	C
523	-	564	2,270	-	2,452	29,420	A	C	C	C	C	C	C	C	C	C
565	-	711	2,453	-	3,088	37,060	A	B	C	C	C	C	C	C	C	C
712	-	857	3,089	-	3,725	44,700	A	A	B	C	C	C	C	C	C	C
858	-	888	3,726		3,860	46,325	A	A	B	B	C	C	C	C	C	C
889	-	1,004	3,861	-	4,362	52,340	A	A	A	B	C	C	C	C	C	C
1,005	-	1,072	4,363	-	4,656	55,875	A	A	A	B	B	C	C	C	C	C
1,073	-	1,150	4,657	-	4,998	59,980	A	A	A	A	B	C	C	C	C	C
1,151	-	1,255	4,999	-	5,452	65,425	A	A	A	A	B	B	C	C	C	C
1,256	-	1,297	5,453	-	5,635	67,620	A	A	A	A	A	B	C	C	C	C
1,298	-	1,443	5,636	-	6,272	75,260	A	A	A	A	A	A	B	C	C	C
1,444	-	1,590	6,273	-	6,908	82,900	A	A	A	A	A	A	B	B	C	C
1,591	-	1,621	6,909	-	7,044	84,525	A	A	A	A	A	A	B	B	B	C
1,622	-	1,736	7,045	-	7,545	90,540	A	A	A	A	A	A	A	B	B	C
1,737	-	1,804	7,546	-	7,840	94,075	A	A	A	A	A	A	A	B	B	B
1,805	-	1,987	7,841	-	8,635	103,625	A	A	A	A	A	A	A	A	B	B
1,988	-	2,171	8,636	-	9,431	113,175	A	A	A	A	A	A	A	A	A	B

SAINT FRANCIS
Hospital and Medical Center

Mount Sinai
Rehabilitation Hospital

a SAINT FRANCIS *Care* Provider

Mt Sinai Campus

APPLICATION FOR FINANCIAL RELIEF

Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Social Security #: _____ Home Phone#: _____

Employer's Name & Address: _____

Number - Household Members: _____ Other Family Income: $_____

Patient's gross income: $_____ Total Family Income: $_____

Service Date(s): _____ Acct #: _____ Balance: $_____

Proof of income provided: _____ Pay stubs *(4 current)* _____ Fed'l Tax Return (most recent) _____ Other: *SSI, State denial*

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance *(Medicaid, Medicare, Insurance, etc.)* which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance.

I understand that this application is made so that the hospital can judge my eligibility for Financial Relief, based on the established criteria of the hospital. If any information I have given proves to be untrue, I understand the hospital may re-evaluate my financial status and take whatever action that is appropriate.

I also understand that all information requested must be received within ten (10) working days from date of request.

_____	_____	_____
Date of request	Person Completing Application	Applicant's signature

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ELIGIBILITY DETERMINATION *(For Office Use Only)*

Date application received: _____ Documentation received: _____

The applicant is **eligible** for %_____ = $ _____ Financial Relief Funds. New balance: $ _____.

_____ The applicant's request for Financial Relief Funds has been **denied** for the following reason(s):

_____ Over-income _____ Did not pursue available resources or failed to comply _____ No income

_____ Other reason: _____

Date determination (deny/eligible): _____ Authorized Signature: _____

1704313 (Rev. 12/07)

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Financial Relief

Patient **must** supply the following documentation in order to determine eligibility:

An application for State Medical Assistance (Medicaid) must be completed for those patients with verified income below 100% poverty guideline. If your request for State assistance is denied, obtain a copy and attach it to your completed Financial Relief Application.

Attach proof of income for the last twelve (12) months for you and your spouse. (Federal Tax Return, most current date)

Attach copy of last two (2) by weekly or last four (4) current pay stubs from date of request for Financial Relief Assistance for you and your spouse *(significant other).*

Attach copy of unemployment, pension, voucher, social security or disability benefits. *(if applicable)*

Provide social security numbers for all dependents listed in the number of family size, if they are not listed on your last Federal Tax Return. Birth certificates may also be requested.

For ***undocumented citizens***, the procedure to grant Financial Relief Funds are as follows:

> Copy of alien status; passport/visa. If you are a permanent resident, but in the US for less than five (5) years, you are ***not*** eligible for State Assistance.

However, your sponsor IS responsible for any financial or medical services that is provided to you. If you have no means to pay this hospital debt and are applying for assistance, you **must** furnish us with your **sponsor's income** to determine your eligibility. Using the same criteria as listed above without the need for State denial. This information must also be received within ten (10) business days from received date or application will be denied.

Any questions or concerns, please feel free to call our office, Monday through Friday; 8:00am – 4:00pm at (860) 714-4952. Thank you

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APLICACIÓN PARA ASISTENCIA FINANCIERA

Nombre:_____

Dirección: _____

de Seguro Social: _____ # de telefono: _____

Nombre y dirección del empleador:_____

Numero de dependientes:_____ Ingreso de otros familiares:_____

Ingreso del paciente: _____ Ingreso total de la familia: _____

Fecha(s) de servicio: _____ # de cuenta:_____ Balance:_____

Prueba de ingreso: Talonarios ____ (4 recientes)	Forma de Impuestos: ____ (recientes)	Otros:_____ (SSI, State denial)

Certifico que la información suministrada es cierta segun mi leal saber. Ademas, haré cualquier aplicación para asistencia (medicaid, medicare, seguros, etc.) las cuales servirán para cubrir las deudas del hospital. Tomaré cualquier acción que sea razonablemente necesaria para obtener dicha asistencia.

Yo entiendo que esta aplicación esta hecha para que el hospital pueda juzgar mi elegibilidad para asistencia financiera, basados en el criterio establecido en los archivos del hospital. Si cualquier información que yo haya proveido prueba ser falsa, yo entiendo que el hospital re-evaluara mi **estado** financiero y tomará la acción que sea apropiada.

Entiendo que la prueba de ingreso debe ser sometida dentro de 10 dias laborables ha partir de la fecha del pedido.

_____	_____	_____
fecha del pedido	Persona completando la Aplicación	Firma del aplicante

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DETERMINACIÓN DE ELEGIBILIDAD (*uso de la oficina*)

Fecha de haber recibido la aplicación:_____ Verificación de Ingreso: _____

El/La aplicante es elegible para % _____ = $ _____ ayuda financiera. Balance actual: $_____ .

El/La aplicante es elegible para _____ % ayuda financiera

_____ El pedido del aplicante para servicios gratis o reducidos ha sido negado por la(s) razon(es) siguientes:

_____ Sobre Ingreso _____ No aplicó para los recursos disponibles _____ Ningun Ingreso
_____ Otros

Fecha Determinante de eligibilidad: _____ Firma Autorizada:_____

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Ayuda Financiera

Los pacientes deberán presentar los siguientes documentos para poder determinar su eligibilidad:

Una solicitud del Departamento de Servicios Sociales debe ser completada para los pacientes con un ingreso menor de 100% de los estándares de pobreza. Si su solicitud para servicios sociales es denegada, favor de obtener una copia y adjúntela a su solicitud de Ayuda Financiera que ofrece el hospital.

Envie prueba de ingreso de los últimos 12 meses de usted y su conyugue. Esto es la Planilla Federal de Impuestos del 2010 (Federal Tax Return).

Envie una copia de los últimos 4 talonarios (suyos y de su conyugue), desde el dia en que la aplicación para Asistencia Financiera del Hospital fue completada.

Si está desempleado y recibe beneficios, envie una copia del comprobante de beneficios de desempleo, del seguro social o de incapacidad.

Provea el número de seguro social de todos los dependientes listados en el encacillado que especifica la cantidad de personas en la familia, y que **no** aparecen en la Planilla Federal de Impuestos Contributivos (Federal Tax Return).

Para ciudadanos indocumentados, el procedimiento para aprobacíon la Asistencia Financiera es como sigue:

- Usaremos el mismo criterio enlistado.
- Necesitamos una copia de su estado legal; por ejemplo, el pasaporte/visa.
- Si es Residente Permanente (tarjeta verde), y ha estado en los Estados Unidos por menos de 5 años, usted no cualifica para asistencia del Estado. Pero, su patrocinador es responsable por todos los servicios médicos o financieros. Si usted no tiene los recursos para pagar su factura y está aplicando para ayuda financiera del hospital, usted debe proveer la prueba de ingreso de su patrocinador para determinar si cualifica para asistencia.

Si esta información no es recibida en 10 dias, la solicitud será negada.

Cualquier pregunta, favor de llamar a nuestras oficinas de lunes a viernes de 8:00am a 4:00pm al 860-714-4952. Muchas Gracias.

SAINT FRANCIS Care Policy	**Title:** **Financial Relief Fund Policy**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** DEPARTMENT OF Patient Accounting	**Number**	**Level** ☐ System ☐ Division ☒ Department
	Category ☒ Administrative ☐ Clinical ☐ HR ☐ EOC	**Published Date** April 1, 2011	**Review Cycle** ☒ 1 year ☐ 3 years

PURPOSE:

It is the policy of Saint Francis Hospital and Medical Center & The Rehabilitation Hospital of CT to ensure a socially just practice for billing patients receiving care at any of its facilities. Financial Relief is a financial assistance program offered by Saint Francis Hospital and Medical Center and The Rehabilitation Hospital of CT for the benefit of our uninsured or underinsured patients who are unable to pay for their care. This policy relates to all medically necessary inpatient, outpatient, clinic, and emergency department visits. **Excluded from this policy are cosmetic procedures, bariatric services, and secured liens on liability cases.**

SCOPE:

This policy reflects our commitment to individual human dignity with special concern for poor and vulnerable persons.

Application for Financial Relief

1. Application may be obtained from the appropriate hospital personnel: Financial Counselors, Collection Representatives, and Telephone Representatives.

2. The completed and signed application must be returned to the Business Office with the following requested documentation, in the return envelope provided:
    a. Family size - as reflected on prior year tax return; and
    b. Income verification – to include one of the following:
        i. Three most current pay stubs;
        ii. A letter from employer or government agency which verifies income AND previous year's tax return; or
        iii. Active Medicaid eligibility screen print that indicates current full Medicaid coverage

    If any of the above required documents are not received the application will be pended for 30 days. A written notification will be sent to the applicant detailing the missing documentation. If not provided within 20 days the application will be denied.

3. An application for State Medical Assistance (Medicaid) must be completed for those patients with verified income below 100% of the poverty guidelines. If the patient is ineligible for Medicaid they will be offered hospital financial relief based on the Medicare allowed amounts.

- If a patient is approved for Medicaid with no spenddown, the proof of eligibility determination from the Department of Social Services can be used as verification of their income and be eligible for 100% financial assistance .
- If the balance on an account is the result of a spenddown the income guidelines will apply to determine eligibility. The Medicare allowed calculation will apply so the balance may not be eligible for financial assistance.

4. Eligibility is determined on family size and current income.

   a. Income eligibility is based on the federal poverty guidelines. Patients with income levels **under 200%** of the federal poverty guidelines who are ineligible for State Medical Assistance will receive 100% financial relief.

   b. Patients with income levels between **200% to 250%** of the federal poverty guidelines who are ineligible for State Medical Assistance will be eligible for financial assistance based upon Medicare allowed amount. This may or may not provide a discount on the patient balance that is owed.

   Self Pay Patients with income over 250% of the federal poverty guidelines will not be eligible for financial assistance but may still receive a self pay discount if applicable.

Examples:

- **If an insurance payment (cash from insurance) is the same or greater than the Medicare allowed amount for the same service, there will be no patient responsibility. The patient balance will be adjusted 100% with the financial assistance code 97000039.**

- **If the insurance payment is less then the Medicare allowed amount the patient is responsible to pay up to the Medicare allowed. Any amount over the Medicare allowed will be adjusted with the financial assistance code 97000039.**

- **Patients with health insurance who have medically necessary inpatient and outpatient services will be eligible to apply for financial assistance in the following instances:**

  - **Reached their maximum benefits**

  - **Entire procedure is non covered due to limitations of their policy or diagnosis**

  Patients within the 200-250% of the federal poverty guidelines will be required to pay the Medicare allowed amount.

  Patients over 250% of the federal poverty guidelines will be granted the self pay discount.

5. The Self Pay Manager and appropriate personnel determine eligibility within 30 days of receipt of a completed application.

6. Assessment for other free bed funding is completed as part of the financial assessment

ADJUSTMENTS GREATER THAN $5,000.00 ARE SUBJECT TO APPROVALS AS FOLLOWS:

$5,000-$24,999 - Supervisor
$25,000-$49,999 - Manager
$50,000-$99,999 - Director of Patient Financial Services
>$100,000 - VP, Revenue Cycle
After obtaining approval, staff will apply adjustment.

To be Noted

- For all financial relief cases where the patient or spouse is self employed, the gross income will be used after the business expenses are deducted. This information is obtained from the "Profit and Loss Statement" or income reported on the 1040 or 1040A.
- Patients seeking financial relief who are under sponsorship of relatives are determined eligible if the sponsor provides the appropriate income/household documentation. Eligibility is determined on income.
- Cosmetic and Bariatric Procedures are excluded from Financial assistance
- Liability Cases that have secured liens are excluded from Financial Assistance
- Undocumented patients who are eligible for Medicaid Emergency Medical coverage (for their inpatient emergency account) are automatically eligible for financial assistance when proof of eligibility is determined from the Department of Social Services.

CROSS REFERENCES:

APPROVED BY: Policy requires Director and Vice President approval.

Director(s): Sarah Alber /s/ Sarah Alber	Date: 6/28/12	Vice President(s): Nicole Schulz	Date: 6/28/12

REPLACES:

REVISED DATE: 10/1/03; 3/15/04;9/01/04; 11/01/04; 03/07/05; 10/01/05; 10/1/06; 3/1/07; 4/11/08; 5/22/09, 7/1/2011, 1/23/2012 , 7/1/2012

SAINT FRANCIS *Care* Procedure	**Title:** BAD DEBT WRITE OFF PROCEDURE		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** **DEPARTMENT BUSINESS OFFICE**	**Number**	**Level** ☐ System ☐ Division ☒ Department
	Category ☒ Administrative ☐ Clinical ☐ HR ☐ EOC	**Published Date** July 1, 2011	**Review Cycle** ☐ 1 year ☒ 3 years

PURPOSE:

The purpose of this procedure is to define how to write accounts off to bad debt.

SCOPE:

This procedure applies to the Business Office-Patient Accounting Department.

PROCEDURE:

A. BAD DEBT WRITE OFF PROTOCOL:

All Self Pay accounts shall be given a 45% discount off of billed charges effective 1/1/12. This discount was applied at the time of initial billing.

Account balances which have not been resolved after a series of 4 patient statements during the dunning cycle which is 120 day assuming no interruptions, automatically becomes eligible for bad debt write-off.

- Exclusions to this protocol are: Mail Returns, Small Balance Write off, Unresolved patient disputes or billing issues, and Bankruptcy discharges. Which may result in early placement to bad debt or early discharge of an account .

The financial class assignment is automatically changed to reflect the corresponding assignment of the bad debt to one of two contracted collection agents. Effective 11/1/2011: Claim inventory is split alphabetically with patient last names beginning with the letters A – MI being assigned to American Adjustment Bureau staff (financial class code 951 - American Adj Bur BD, financial class code 953 - BD Mcare SP - AAB) and the remainder of the alphabet MJ - Z being assigned to Nair & Levin staff (financial class code 920 - Nair & Levin BD, financial class code 972 - BD Mcare SP - N&L).

- A report of accounts eligible for bad debt greater than $5,000 is generated and distributed to the Self Pay Manager, Director and Vice President.

The account balance is subsequently removed from the active accounts receivable and at month end, the system will automatically write off accounts in these financial classes which becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt.

Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above. Upon culmination of the 180 day holding period, any unpaid balances will be returned to the hospital.
Accounts that are returned as uncollectible may be considered for secondary placement with a contracted collection agency EOS CCA. The appropriate returned transaction code is applied to the account and the financial class is changed to 931 EOS CCA bad debt 932 EOS CCA Med Bad Debt. An electronic inventory is sent to the collection agency to pursue accounts for an additional 180 days. Any unpaid balances will be returned to the hospital.

B. Write Off/Account manually:
Accounts that need to be written off manually to an outside Collection Agencies can be flagged for write off by simply changing the Financial Class of the account to the agency.

- Other agencies should be written off in the following manner:
  1) Change the Financial Class to the Agency
  2) SFS Pathway is: PA, PM, AR, WO - In the write off service code enter 97111111
     In the balance forward service code enter 97970000
     Answer Yes to the write off question.
- Example:

Name: KOLE SUSAN	VT: I	Acct: 100000095		Acct. Bal: 1300.00
AR Per: Entire Account	AS: A	FC: SAGA/CITY(REVENU		Per Bal: 1300.00

Write-Off Service Code: 97111111 BAD DEBT MOVE
Balance Forward Service Code: 97970000 SFS BAD DEBT WRITE O

Write-Off This Account? YES

This account will now be in Bad Debt status. The account balance will still show, but is in the Bad Debt receivable.

C. <u>REACTIVATING A BAD DEBT ACCOUNT:</u>

- The write off reactive function in the PM menu should be used to bring the account back from bad debt. PA/PM/AR/WO. The codes to use are 972222222 AR Move in the reactivate the account and 97970000 as the Balance forward code.

- Example:

Name: ABERNATHY DENISE	VT: C	Acct: 50230028799		Acct Bal: 135.31
AR Per: Entire Account	AS: B	FC: ELIG MEDICAID AUT		Per Bal: 135.31

Re- Activate Service Code: 97222222 AR MOVE
Balance Forward Service Code: 97970000 SFS BAD DEBT WRITE O

Re-Activate This Account? YES

C. WRITING ACCOUNTS OFF TO ZERO BALANCE:

- The write off to Bad Debt is only intended for accounts that are being followed up by agencies. Accounts being written off for other reasons (i.e. Denied timely filing, bankruptcy, etc.) should be done through transaction entry. PA, PM, FIN, TE.
- The following adjustment codes should be used:
  - ⇒ 97000011 - Bad Debt Wo
  - ⇒ 97000023 - Small Balance
  - ⇒ 97000026 - Bankruptcy
  - ⇒ 97100085 - Medicare
  - ⇒ 97000610 - Denied Timely Filing

(All other bad debt write off codes have been inactivated so you will not be able to use them.)

These accounts will not turn to bad debt status, but will go to zero balance.

D. INTERRUPTION OF DEBT COLLECTION PROCESS

- All outside collection agencies will be providing a copy of the hospital free bed/financial assistance summary in all communication to a patient. (i.e. hospital one page summary sheet).
- At any time during the collection process, if the collection agency has determined that the patient may qualify for a free bed fund or financial assistance, the account will be referred back to the hospital. At this time all outside collection activity will stop until financial assessment is completed.

E. Second Placements

- The Hospital reserves the right to send accounts that have been closed by the primary collection agency to a secondary agency for further collection efforts. The above process will remain the same for secondary placements..

REFERENCES:

CROSS REFERENCES:

APPROVED BY: Policy requires Director approval.

Director(s): Sarah Alber	Date:		
/s/ Sarah Alber	3/21/2012		

REPLACES:

January 23, 2009 procedure

SAINT FRANCIS Care Procedure	Title: **Self-pay Billing & A/R Management**		
☒ Saint Francis Hospital and Medical Center ☒ Mount Sinai Rehabilitation Hospital ☐ Saint Francis Medical Group, Inc. ☐ Saint Francis *Care* Medical Group, P.C. ☐ Asylum Hill Family Medicine Center, Inc. ☐ Saint Francis Behavioral Health Group, P.C.	**Proponent Department** **DEPARTMENT BUSINESS OFFICE**	**Number**	**Level** ☐ System ☐ Division ☒ Department
	Category ☒ **Administrative** ☐ **Clinical** ☐ **HR** ☐ **EOC**	**Published Date** July 1, 2011	**Review Cycle** ☐ 1 year ☒ 3 years

PURPOSE:

It is the policy of Saint Francis Hospital & Medical Center that all patients who have received services and that have outstanding financial obligations are given fair and objective opportunities to satisfy these responsibilities. To that end, Saint Francis Hospital commits to the following:

- All patients/patient guarantors shall receive a complete and patient statement detailing encounter specific information including dates of service, summary of charges, discounts applied, and amounts owed.
- Patients/patient guarantors will be properly informed of the various options available to satisfy their outstanding financial obligation(s) including assistance through the state of Connecticut's Medicaid Assistance Program as well as through St. Francis Hospital's internal financial relief program, and recurring payment plan guidelines.
- Patients/patient guarantors will be given a maximum of 120 days to resolve or set up a payment plan to satisfy an outstanding financial obligation before the account is eligible for bad debt.
- Patients/patient guarantors will be treated with respect and compassion in accordance with the Saint Francis Hospital & Medical Center mission.

SCOPE:

This procedure applies to the Business Office-Patient Accounting Department.

PROCEDURE: **Self-Pay Billing: Execution of the Self Pay Dunning Cycle**

All patient encounters for which the patient or the patient's guarantor are financially responsible for the unpaid balance, are inherently held by the billing application for the current lag day determine by the billing process to ensure all necessary charges, codes, and activity has been completed prior to submission. Upon expiration of this lag period, three concurrent processes are executed. First, the account balance associated with the patient encounter is moved from pre-receivable status to active accounts receivable status in the hospital's billing and accounts receivable system. Second, a patient statement displaying both total charges and the outstanding balance after any discounts have been applied, is generated and mailed to the patient through a contracted agent. Finally, a file containing the billed inventory is electronically transferred to a contracted self-pay collection agents to initiate account resolution activities. These three events coincide with the execution of the self-pay dunning cycle. The dunning cycle defines the submission interval between patient statements (i.e. - datamailers) as well as the various messages included on those statements. Each datamailer in the dunning cycle includes a

specific message as to the delinquency status of the account. The dunning cycle can be reset to previously issued datamailer statements through one of two means: Business Office staff can manually reset the dunning cycle or a change in the encounter's financial class. Primary self-pay balances, or those balances for which there is no insurance coverage, will receive a series of four statements beginning at day five (from billing) and with dunning cycle statement message number one. Self-pay balances resulting from an insurance payment will receive a series of four statements beginning five days from the financial class change to self-pay and with dunning cycle statement message number one. A file containing the billed inventory is electronically transferred to a contracted self-pay collection agent to initiate account resolution activities after billing statement cycle 2.

The statement intervals for both are generated in 30 day intervals and the entire dunning cycle, assuming no interventions, lasts 120 days.

Self-pay A/R Management: Execution of Self-pay Collection Efforts

Collection efforts on self pay claims are assigned to a contracted collection and customer service agent from the day of billing. Upon generation of the self-pay claim, the encounter's financial class assignment is changed to reflect the agent to which the account is being assigned. Effective: 3/28/2011 all claim inventory is assigned and sent to American Adjustment Bureau staff (financial class code 959 - SP day One - AAB, financial class code 954 - SP Mcare Day One - AAB).

The contracted agent receives daily billing files as self-pay claims are generated. The Contracted agent submits a daily acknowledgement file to the hospital to confirm receipt of the assigned inventory. The acknowledgement file is posted on the Self Pay folder in the business office shared drive to expedite reconciliation of the assigned inventory.

Follow-up and collection activities will commence within ten days of receipt of the referral. Accounts are continuously prioritized throughout their lifecycle according to balance and circumstance and run through a predictive dialer application/voice broadcasting system to establish initial contact with the patient/patient guarantor. Patients whose established phone number has a voice answering system are left pre-recorded messages indicating the nature of the call and requesting them to contact the St. Francis Billing & Customer Service Department at the appropriate toll-free number. All patients are given an option to speak with a live customer service representative during the initial contact. Follow-up call intervals through the dialer are accelerated during the early phases of the billing process but are also coordinated with the corresponding issuance of patient statements from the hospital's billing system and as defined by the self-pay dunning cycle. Patients who have occasion to speak with a customer service representative shall be greeted in a courteous and professional manner and with an intention to resolve the outstanding balance in a mutually beneficial manner. All patients shall be made aware of the various financial assistance options available to them including but not limited to assistance through the state of Connecticut's Medicaid Assistance program as well as St. Francis' internal financial relief program and recurring payment plan guidelines.

Documentation of real time follow up activity is entered directly into the hospital's billing and accounts receivable system and applied through a generic canned comment that collection staff will expand on to include as much content as deemed necessary to convey the patient interaction.

Self-pay Write-offs: Execution of Bad Debt Write-off Protocols

If after 120 days from self-pay bill date, the account balance has not been resolved, the account becomes eligible for bad debt write-off. The financial class assignment is changed to reflect the corresponding assignment of the bad debt to one of two contracted collection agents. Effective 11/1/2011: claim inventory is split alphabetically with patient last names beginning with the letters A – MI being assigned to American Adjustment Bureau staff (financial class code 951 - American Adj Bur BD, financial class code 953 - BD Mcare SP - AAB) and the remainder of the alphabet MJ- Z being assigned to Nair & Levin staff (financial class code 920 - Nair & Levin BD, financial class code 972 - BD Mcare SP - N&L). The account balance is subsequently removed from the active accounts receivable and becomes part of the bad debt receivable. Any patient payments secured on this receivable are classified as recoveries to bad debt. Contracted agents will pursue recoveries of referred accounts for a period of 180 days and perform similar referral management and collection activities as described above. Upon culmination of the 180 day holding period, any unpaid balances will be returned to the hospital.

Accounts that are returned as uncollectible may be considered for secondary placement with a contracted collection agency EOS CCA. The appropriate returned transaction code is applied to the account and the financial class is changed to 931 EOS CCA bad debt 932 EOS CCA Med Bad Debt. An electronic inventory is sent to the collection agency to pursue accounts for an additional 180 days. Any unpaid balances will be returned to the hospital.

PROCEDURAL ELEMENTS:

(Note: Readers of this policy and procedure document should be cognizant of the interchangeable terminology that is used to convey accountability, ownership, and overall responsibility to the tasks set forth. As such, St. Francis Hospital may be hereafter referred to as "the hospital" or "the facility". Collection agency staff may be hereafter referred to as "collection agent", or "collection staff", or "customer service agent", or "customer service staff").

Discounting **-** The hospital currently applies a discount of 45% on all self-pay claims at the time of billing with the exception of outpatient clinic services that are registered under the various sliding scale options available to the patients based on a formal financial evaluation of income and family size. The hospital's billing and accounts receivable system automatically discount the account at the time of bill generation. Any additional discounts are subject to the policies set forth in the *Administration of Financial Relief and Assistance* section of this document and the hospital's official policy on financial relief and assistance. Insured patients who become responsible for outstanding balances as a result of charges being applied to a deductible or due to a policy based co-pay are similarly eligible for these discounts. However, any such discount that is deemed appropriate based on an evaluation of income and household size must be allocated manually by collections and customer service staff.

1. ***Processing Financial Relief Applications*** **-** All self-pay patients shall be made aware of the facility's financial assistance policy as a method of satisfying their outstanding obligation. Collection and customer service staff shall communicate the potential availability of financial assistance as part of its telephone salutation scripts. Upon confirming that the patient may wish to apply for financial relief, the customer service agent shall perform an initial screening to determine eligibility.

The customer service agent can make a preliminary determination of eligibility and the amount of

financial assistance or recommend that a Medicaid application be filed and communicate such to the patient. The customer service agent is instructed to caveat this determination upon the completion of a formal financial relief application and the submission of required and qualified documentation to the hospital. Please refer to the full version of the facility's financial relief and assistance policy in Appendix E of this document.

Processing Payment Plans - All claims for which collection staff has established a recurring payment arrangement with the patient/patient guarantor will be placed into one of two financial class designations, SP Budgets - AAB BUDGET (financial class code 957) or SP Medicare Budgets – AAB MCARE (financial class code 967) for accounts that are assigned with the agency. These designations will receive an alternative self-pay dunning cycle from the time of placement and are exempt from any bad debt write-off protocols. All efforts should be made to establish payment plans that resolve an outstanding balance within a reasonable time period. Collection staff should utilize to the following guidelines as a tool when structuring time based payment arrangements. We accept payment arrangements as long as we receive a consistent payment every month. Once a payment is missed, the account will be considered in default and may be eligible for Bad Debt.

Outstanding Balance	Time Frame	Maximum Average Monthly Payment
Less than or equal to $2,400.00	12 months	$200.00
$2,401.00 - $4,800.00	24 months	$200.00
Greater than $4,800.00	Less than 36 months	Case Specific

Collection staff shall reset the dunning cycle in accordance with the procedure documented in Appendix B of this document for this exclusion code. If a contract is not returned, the account shall continue its procession through the general self-pay dunning cycle and subject to all protocols associated with such including bad debt write-off. Upon receipt of the contract, collection staff shall move the account into the aforementioned agency based budget financial class and document the established payment plan by notating the terms of the contract. Returned and signed contracts shall be scanned for storage and future reference. Payments are expected to be made every thirty days. Self-pay collection staff will review all accounts placed into the aforementioned financial class designations daily to ensure that accounts are not delinquent according to the terms set forth in the payment plan contract. Collection efforts starting at Day 15 through Day 60 are as followed:

Delinquent Budget Statement Cycle	Statement Notification	Collector Follow up
Day 15	1st Late Notification	Minimum of one weekly phone call
Day 30	2nd Late Notification	Minimum of one weekly phone call
Day 45	3rd Final Notification	Minimum of two weekly phone call
		SFS Financial Class Change to 965 Budget to Bad Debt
		Reason Code 61 Eligible for Bad Debt.

Follow-up protocols for delinquent accounts call for a series of 3 statements and a minimum of one weekly phone contact. Contact efforts shall be documented in detail on the account. Should an account become delinquent at day 15, the first late notification statement is generated. If a payment is not received by day 30, a second late notification statement is generated. At 45 days past due, a third delinquent notification statement is generated. If a payment is still not received within 15 days, the account is manually reviewed for referral to bad debt. Collection staff should review the dunning history and account comments. The collection staff should return the account, by changing the financial class in the hospital's billing and accounts receivable system to 965 Budget to Bad Debt, reason code 61 Eligible for Bad Debt. The account is then subject to all protocols associated with the bad debt write-off.

Processing Payments by Phone - St. Francis accepts all forms of payment including cash, check, all major credit cards (Visa, Mastercard, American Express, Discover), and money order and can also accommodate any other transfer of funds including wire transfer. Payments and payment information shall be accepted and encouraged by phone. Collection staff shall complete a payment information form. All necessary information shall be collected as determined by the form and the payment information shall be entered into the Saint Francis Care website for online payments. Denials for funds shall be securely returned to the originating collection agent for appropriate follow-up with the patient/patient guarantor.

Processing Patient Refunds - Collection staff shall review credit balance reports on a regular basis to identify those accounts that are in a credit balance condition as a result of transaction activity. Payment and adjustment history on the account shall be reviewed to determine if the account has been truly overpaid or an appropriate adjustment is required. Upon confirming the legitimacy of the overpayment, collection staff will review the account history for the patient to determine if there are other outstanding balances to which the overpayment can be applied. If another account with an outstanding balance is available, collection staff shall escalate the account to the Self-pay Support Services Manager who will coordinate the transfer of the overpaid amount to the outstanding balance on the other account. Should the account be determined to be an overpayment and there are no other outstanding balances for which to apply the overpaid amount, then collection staff shall disposition the account with the appropriate return code at which point, the hospital's patient refund specialists shall process the refund to the patient within 60 days of identification.

Processing Recovered Insurance Information - Prior to billing, all primary self-pay accounts will be run against the hospital's automated eligibility verification system to identify potential insurance coverage through Medicaid and Medicare. Should the inquiry yield valid third party insurance coverage, the hospital's benefit verification specialists will manually update such information in the hospital's billing and accounts receivable system and re-bill the account accordingly (prior to assignment to the respective agent). Once billed, patients will have the ability of submitting valid third party insurance coverage on the back of the statement stub or over the phone to a customer service representative. Coverage through the stated insurance will be verified through an appropriate eligibility verification medium, updated in the hospital's billing and accounts receivable system, and re-billed to the new payer of record accordingly. Collection staff shall disposition the account with return code 95000093 to close their responsibility to the account (Please refer to Appendix B for a complete list of policy specific exclusion and return codes).

Processing Patient Inquiries/Complaints - The hospital has identified the following as the most common reasons that patients/patient guarantors will inquire and/or contest a bill. Such cases will be excluded from bad debt write-off protocols until the inquiry has been deemed resolved. Collection staff will be required to investigate the validity of the inquiry through the appropriate channels and render a formal determination back to the patient/patient guarantor within 30 days from the date of initial inquiry.

> ***Inquiries related to charges on the account – REFER TO SELF PAY MANAGER***
> ***Inquiries related to the accuracy of the date of service - REFER TO SELF PAY MANAGER***
> ***Inquiries related to being seen/being treated/leaving AMA - REFER TO SELFPAY MANAGER***

Processing Special Guarantors - As part of the hospital's access management policy, service areas are instructed to identify special handling of accounts through registration. The following guarantors are used to identify these special circumstances. All such cases are registered with one of the following hospital addresses:

- 114 Woodland Street, Hartford Connecticut 06105
- 500 Bluehills Avenue, Hartford, Connecticut 06105
- 490 Bluehills Avenue, Hartford, Connecticut 06105

Bills for claims with these guarantors are filtered out by the hospital's statement vendor and reported back to the hospital for review and appropriate action (Note: Contracted agencies must exclude all such cases from any collection efforts until management review is completed). Collection staff shall disposition these claims with the appropriate return code upon applicable reprocessing. Collection staff shall apply a dunning cycle hold on all accounts deemed special guarantors until management review is complete and such determination is made that the patient/patient guarantor is in fact responsible for the outstanding balance.

Cosmetic - Plastic surgery cases for which specific payment arrangements between the patient and the doctor are made need to be tracked to ensure proper payment posting and resolution of the difference between the total charge and the agreed upon payment. Collection staff is instructed to ensure that proper payment has been posted to the account by reviewing system documentation and verifying the nature of the agreement. In situations where there is no documented evidence of the agreement, collection staff shall contact the physician's office directly and request a written agreement/notification between doctor and patient be provided. Upon verifying such, the residual account balance is written off to the contractual allowance code of 97000357. Should the collection agent confirm that the patient/patient guarantor still owes a remaining balance, he/she shall release the dunning cycle statement hold so that the patient may continue to receive his/her notices indicating the remaining balance due. All other follow-up and collection activities apply.

Risk Management - Cases for which Risk Management is the entered guarantor are forwarded to the Risk Management Office for review and the account is documented as such. If, upon review, the Risk Management office deems the hospital accountable for the case, it will notify the Business Office as such. The account will be documented in the hospital's billing and accounts receivable systems and written off to the appropriate administrative adjustment code of 97000064. Should the collection agent confirm that the hospital is not responsible for the balance and patient/patient guarantor still owes a remaining balance, he/she shall release the dunning cycle statement hold so that the patient may continue to receive his/her notices indicating the remaining balance due. All other follow-up and collection activities apply.

Pulmonary Grant – Change Financial Class to Institutional

Occupational Health –Change Financial Class to Institutional

Homeless - Cases for which the patient has been confirmed as undomiciled at the time of service are documented by collection staff and the account balance shall be written off to the appropriate adjustment code of 97000037.

Business Office Director - This guarantor is used as a mechanism to identify and review any other patient claims that may be of an extraordinarily sensitive nature.

Processing Bad Addresses - Patient statements will include a return address corresponding to the contracted agent thus ensuring bad addresses are returned to the agent's dedicated P.O. Box for reprocessing. Collection staff will research address solutions and update the hospital's billing and accounts receivable system accordingly. Possible sources of address verification include the hospital's billing and accounts receivable system, eligibility verification applications, address verification technology, and the internet. Should collection staff be unable to secure a valid address the account will be dispositioned as a "bad address" returned to the hospital by changing the Financial Class to 966 (Incorrect Address) Reason Code 61 Eligible for Bad debt where it will be written of as a bad debt.

Pursuit of Legal Resolution to Outstanding Debts: REFER TO SELF PAY MANAGER

Excluding Accounts from Bad Debt Write-off - The hospital has identified the following circumstances as valid reasons for excluding an account from being written off to bad debt at the designated 120-day time frame. In order to prevent such accounts from being written off, collection staff will notify the Self Pay Manager who will place a hold on the dunning cycle statement counter so that they will remain on the active accounts receivable when automated bad debt write-offs are executed at the end of each month.

REFERENCES:

CROSS REFERENCES:

APPROVED BY: Policy requires Director approval.

Director(s): Sarah Alber	Date:		
/s/ Sarah Alber	1/21/2012		

REPLACES:

June 1, 2007 procedure